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Headline: Anthrax and pregnancy

From Bureau of Medicine and Surgery

WASHINGTON -- Just mention vaccinating against anthrax and some people imagine the worst of side effects, without even understanding the vaccine's life-saving benefits. This may particularly concern women who plan to or might become pregnant during their vaccination series. Women can be assured, however, that there really isn't a scientific or medical reason for anxiety about the vaccine.

At the Centers for Disease Control and Prevention (CDC) in Atlanta, infectious disease experts agree the overall benefits of the anthrax vaccine far outweigh any potential side effects. Dr. Steve Ostroff, associate director for epidemiologic science in the National Center for Infectious Diseases, one of the components at the CDC, emphasized that the anthrax vaccine has a long history of safety and effectiveness with few side effects reported. The vaccine has been used safely since it was approved by the Food and Drug Administration in 1970.

"We know anthrax vaccine doesn't hold any greater risks to the developing fetus than virtually any of the other bacterial vaccines," Ostroff said. "As far as [the CDC] is aware, there are no special risks associated with this vaccine if by chance it is given to someone who is pregnant.

"That's because vaccines made from killed material tend to have a low incidence of side effects. The anthrax vaccine doesn't include anything that's live. There isn't a

risk of getting the disease."

However, just to be on the safe side, women who are pregnant should not get any vaccinations, according to Ostroff.

"As a rule, [the CDC] recommends that women who are pregnant should not receive any vaccines that aren't essential during their time of pregnancy," Ostroff said. "It's based on prudence more than anything else, because there might be a risk that hasn't been recognized and the cautious course is to wait until the pregnancy is over."

However, if a pregnant woman may be exposed to a disease, most experts agree that the best course might be to give her a vaccine rather than doing nothing. For example, it is safer for a pregnant woman exposed to anthrax to receive the vaccine rather than risk coming down with the disease itself.

No specific studies have been done on pregnancy and the anthrax vaccine, Ostroff admitted. But this is not unusual. "With a lot of the vaccines, not just anthrax, and even with a lot of the common medications we use on a day-to-day basis," he said, "there haven't been studies that have specifically looked at their use in pregnancy.

"For instance, when you read the labels very carefully on a lot of medications, it will say the risks in pregnancy or with children aren't very well defined. That's because specific medical studies on those particular groups haven't been done. So, you'll see warning labels about their use during pregnancy. The warning is not because there is a definite risk, but just because studies haven't been done on that specific population."

If a woman discovers she is pregnant after receiving one or more doses of anthrax vaccine, she should receive no further doses until she is no longer pregnant. This situation should not necessarily prompt any action regarding the pregnancy, but should be discussed with her obstetrician or other health care provider. Also, she need not wait a certain period of time following pregnancy before receiving another dose.

There have been no reports of adverse reproductive outcomes (infertility, fetal harm, etc.) associated with administration of the vaccine since it was licensed nearly 30 years ago. This, coupled with knowing how the vaccine is comprised of non-infectious components, lends confidence that the vaccine can be safely administered to women with little concern for any problems associated with pregnancy or fertility.

More information on the anthrax vaccine and the Navy's Anthrax Vaccination Implementation Plan can be found on the Navy Environmental Health Center website, www-nehc.med.navy.mil.

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Headline: Schools form partnership to train medical lab technicians

By LT Lisa Brackenbury, Naval Medical Center Portsmouth

PORTSMOUTH, Va. – The Naval School of Health Sciences at Naval Medical Center Portsmouth, and Thomas Nelson Community College in Hampton, Va., recently formed a unique partnership to train Navy Medical Laboratory Technicians. Starting in early1999, Navy personnel selected for technician training will be enrolled in either the new pilot program at the community college or the traditional Navy technician's school in San Diego, Calf. The Navy's partnership with the community college represents a new way of thinking for training Navy medical professionals. The students will attend the Hampton-based school for the first six months of classroom work. After that they will complete the second half of the course with six months of laboratory work at Naval Medical Center Portsmouth's new laboratory in the Charette Health Care Center. The pilot program initially will enroll 24 Navy students in the first class on January 7, 1999, and will eventually increase to more than 55 students per class from all military services. The second class will start in July 1999.

"We've never done this before," said LCDR Harvey Vandenburg, MSC, who is head of medical laboratory technician training at the Naval School of Health Sciences.

"This gives us the chance to tap into civilian expertise that before we just did not have the opportunity to use. We're hoping that it will also offer some cost savings."

Because medicine is a dynamic field, the technicians must possess the most recent medical and technological knowledge, something that is not always possible with the present training. Vandenburg said the pilot program will go a long way toward meeting this continual challenge.

Military personnel interested in being enrolled in the pilot program with the community college should contact LCDR Harvey Vandenberg, MSC, at Thomas Nelson Community College at (757) 825-2947.

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Headline: Medical evacuation across Australia

By LT Andrew D. Danko, USS O'Brien (DD 975)

YOKUSUKA, Japan – While his ship was heading for a liberty port in Australia during a recent Arabian Gulf deployment, a Sailor aboard the USS O'Brien (DD 975) reported to medical personnel complaining of a migraine-type headache. He was treated and released, and a few days later he returned to medical with the right side of his face completely paralyzed, blurred vision and growing numbness throughout the right side of his body. After examination by Chief Hospital Corpsman Maria Moore, it was determined that the patient required medicine not carried on a Spruance-class destroyer.

Moore notified the ship's commanding officer that a medical evacuation, using the ship's SH-60 Seahawk antisubmarine helicopter, was necessary. The navigation charts revealed that the sparsely populated Australian

outback had only two cities with suitable medical facilities: Perth was 1,000 miles away to the south and too far for the evacuation. Darwin, which was 500 miles to the northeast, was selected.

The Australian government, through the United States Defense Attache Office in Canberra, informed the O'Brien that no other assets were available to assist and gave permission for the helicopter to fly to Darwin.

Because of the aircraft's refueling requirements, the flight would not be a straight run for Darwin. The Australian Air Force coordinated two fuel stops along the way at the towns of Derby and Kununurra.

The helicopter's crew, LCDR Eric Patten, LT Andrew Danko, Petty Officer Third Class Darin Droll and Hospitalman Robert Mauricio, were determined to arrive at Darby with their patient, who was stabilized and had fallen asleep shortly after takeoff.

As Mauricio tended his patient, the aircraft continued through the night on its ten-hour flight crossing part of Australia's Great Sandy Desert and the Kimberley Mountain Range. After flying nearly 850 miles, the helicopter arrived in Darwin, where Royal Australian Air Force personnel and an ambulance transported the patient to a local hospital.

Medical personnel at Darwin later reported they were unsure of the cause of the paralysis but said that the evacuation had at the very least saved the patient's eyesight. It was a massive cooperative effort that helped the O'Brien's crew member. It began with the medical team and the ship's company combining resources to treat and evacuate the Sailor. Then, cooperation between American and Australian forces facilitated the flight to Darwin. Bravo Zulu to all who supported the effort.

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Headline: Top health benefits advisor named for 1997

By Earl W. Hicks, Bureau of Medicine and Surgery

WASHINGTON – The Navy recently named Charles Meeds, Naval Medical Center San Diego, as its top Health Benefits Advisor (HBA) for 1997. Meeds will receive the CDR James T. Kirch award, which is presented annually to a Health Benefits Advisor whose work exhibits knowledge, customer service, professionalism and enthusiasm.

The award's namesake, the late CDR James Kirch, MSC, was assigned at various times to the Bureau of Medicine and Surgery in Washington, D.C.

He was a strong proponent of beneficiary health care. He was also instrumental in the development of TRICARE, beginning with the CHAMPUS Reform Initiative in the late 80s, which later became TRICARE.

Meeds, a former Senior Chief Hospital Corpsman, was selected this year from among ten other nominees for his extensive knowledge of health care issues and consistently excellent service to his customers.

“My job is to help beneficiaries understand their [medical] benefits and how to use them,” he said. “It has become increasingly more complicated as years go by and new programs develop. We help beneficiaries coordinate their insurance. It gets very confusing for them, so the HBA tries to keep things simple.”

Meeds said that the he sees the HBA role changing.

“We are going to see more HBAs going into the community,” he said, “working on the premise that it is easier to prevent a problem (such as teaching preventive medicine) than it is to solve it.”

People have made phone calls or stopped by to see Meeds to let him know how much they appreciated his assistance. One customer, who Meeds helped through some difficult claims issues, had a beekeeping hobby and showed his appreciation by presenting Meeds with a jar of honey.

Other recognition of his work ranges from the commanding general of the Marine Corps Recruit Depot San Diego to a Marine in the brig who needed assistance resolving a bill, to parents he helped when their child was severely ill.

Meeds and other HBAs around the world provide a bridge between the healing process and coordination of health care benefits for beneficiaries.

Congratulations to the others who were also nominated for the ’97 CDR James T. Kirch award:

- Marsha Childs, Naval Hospital Jacksonville, Fla.
- Dale Fuller, Branch Medical Clinic, Naval Amphibious Base, Little Creek, Va..
- Dona Gatewood, Naval Medical Clinic Pearl Harbor, Hawaii
- Janice Heaton, Naval Medical Clinic Annapolis, Md.
- Shirley Kahl, Naval Hospital Corpus Christi, Texas
- Richard Leonard, Chief Hospital Corpsman, Branch Medical Clinic, LaMaddalena, Italy
- Estella McKanna, Naval Hospital Great Lakes, Ill.
- Daniel Mutuszak, United States Naval Hospital Yokusuka, Japan
- Peggy Terry, Branch Medical Clinic, Naval Weapons Station, Concord, Calif.
- Nona White, Naval Ambulatory Care Center, Port Hueneme, Calif.

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Headline: Veterans Administration plans new outpatient clinic locations

From Veterans Administration Public Affairs

WASHINGTON -- The Department of Veterans Affairs (VA) announced plans to open new community-based outpatient clinics in nine communities as part of its continuing emphasis on making VA medical care more accessible and closer to veterans’ homes.

Three of the new clinics are designated for Indiana locations and two will be located in Missouri. The remainder will be in Pennsylvania, Florida, Wisconsin, and Kansas.

Veterans Administration Under Secretary for Health

Kenneth W. Kizer said that this is the third round of clinic announcements this year, further increasing the options for veterans to receive VA care in the most appropriate setting for their needs.

"A pivotal element of VA's reengineering is the shift from a hospital, bed-based system to an ambulatory care-based system," Dr. Kizer said. "Today's announcement brings the number of clinics approved this year to more than 80, and the total number approved since 1996 to more than 200."

Each of VA's 22 health networks around the country is continuing to examine where the need for clinics will be greatest, both short range and in the long term. Overall, VA has more than 600 outpatient clinics of various types.

VA's emphasis on outpatient care reflects a trend in American medicine in general. New technology allows more and more conditions that once required hospitalization to now be treated on an outpatient basis.

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Headline: Portsmouth 'Doc' has championship game

By Dan C. Gay, Naval Medical Center Portsmouth

PORTSMOUTH, Va. -- Which of the following players have not won a tennis championship: Stan Smith? Arthur Ashe? Patrick Lawson? Jimmy Connors? The answer is -- they all have. While Smith, Ashe and Connors are familiar names to tennis buffs, Lawson may not be. Although he has not played at the U.S. Open, Wimbledon or the French Open he recently won a major championship.

Lawson, a lieutenant commander in the Medical Corps and surgical pathologist assigned to the Naval Medical Center Portsmouth, captured the Armed Forces Riseley Bowl singles championship played in early August at Fort Eustis, Va. He also won the silver medal in the doubles championship.

Coincidentally, as members of the Army, 2nd Lt. Arthur Ashe won the 1968 championship and PFC Stan Smith won the championship in 1971. Lawson, only the fifth Navy champion in the history of the cup, won nine matches including the finals match by a score of 6-1, 7-5.

The Risely Bowl "Challenge Cup" was presented to the then United States Lawn Tennis Association by A. H. Riseley, chairman of The Executive Committee, of The Wimbledon All-English Lawn Tennis Club, to be competed for by members of the U.S. Armed Forces. The competition began immediately following World War II.

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Headline: TRICARE question and answer

Question: How do I get help in solving my problems with TRICARE?

Answer: Perhaps you have recently tried to resolve a TRICARE problem and weren't completely happy with the results. Maybe you called a TRICARE Service Center (TSC) and received incorrect information. Or, maybe your TRICARE

Prime primary care manager referred you to a specialist who is not in the TRICARE Prime network, and the claims processor handled the resulting claim as a more-expensive "point-of-service" claim.

Or, maybe you went to a provider who you thought was authorized to render care under TRICARE Standard, only to find out afterward that the contractor hadn't processed the provider's certification request in a timely manner. The end result is you got care from an "unauthorized" provider, and now the government won't pay any of the bills.

Problems such as lost claims, incorrect processing and so forth can occur when processing claims. But the bottom line is, you've got a complaint, and you want to know what to do about it?

The first thing you need to do is let someone know what the problem is. Give the system a chance to help you resolve the issue. One place to start is your nearest TSC. There you can discuss a problem with staff members or possibly file a grievance.

TRICARE contractors have established TSCs throughout the regions they serve, and TSC staff may be able to help you resolve the problem at that level, with only a phone call on your part. Depending on the problem, you might want to write a letter instead of phoning, so that a paper record of your attempts to resolve the difficulty will be established. Include all documents that are relevant to the problem, and be sure to keep copies of everything for your own records.

Whatever method you choose, keeping the communication process civil and rational can help expedite the process of getting your problem solved. If your efforts at the TSC level fail, try writing a letter to the contractor's headquarters. Explain the problem, and state what sort of resolution you'd like to see. Another option for those living near a uniformed services medical facility is to present unresolved issues to the service hospital's point of contact. That person may be a patient advocate, someone in the managed care office or the hospital's contracting officer's technical representative.

Military hospitals welcome the chance to work with TRICARE contractors and help get TRICARE issues resolved to everyone's satisfaction. If other means fail, you may call (303) 676-3526, or write to the TRICARE Management Activity's Benefit Services office, 16401 E. Centretech Parkway, Aurora, Colo., 80011-9043. Staff members in this office are government employees who help TRICARE-eligible customers with problems they haven't been able to resolve with their regional TRICARE contractor. Again, be sure to include copies of all documents that are relevant to your problem, and make sure you keep either copies or originals of each document for your own records.

TRICARE contractors process 25 million claims per year, nearly half a million claims every week. Standards for the contractors require that, to perform satisfactorily, they must process at least 75 percent of all claims within 21

days after receipt. Claims processing contractors for all TRICARE regions are currently meeting or exceeding the standards.

Accuracy in the processing of claims is also a high priority for contractors. If even one percent of all claims received is processed incorrectly, that's 250,000 or more claims per year. Perfection may not be possible, but each contractor strives for the highest levels of accuracy in claims processing.

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Headline: Healthwatch: Cholesterol Facts
By LT Scott Pusateri, MC, Naval Hospital Pensacola

PENSACOLA, Fla.--More than 97 million American adults have it, and no, the 'it' is not Viagra. What nearly half the population of America has is a leading risk factor for heart attacks – high cholesterol. And it is a health problem that can be prevented.

Cholesterol belongs to a group of compounds known as lipoproteins. Fats, also called lipids, are carried in the blood by joining proteins to form lipoproteins. When more lipoproteins are present than the body needs, deposits form in blood vessels. This process of arteriosclerosis, or hardening of the arteries, is a risk factor for heart attacks.

Total cholesterol levels are important, but other lipoproteins also have a role in heart disease. Low-density lipoproteins or LDLs, are lethal. They are especially good at creating fat deposits. On the other hand, high-density lipoproteins or HDLs, can be remembered as "healthy" because they keep cholesterol deposits from forming. In fact, high HDL levels can decrease the risk of heart attack.

Because there are rarely symptoms of dangerous cholesterol levels, testing is required. Most medical authorities advise us to begin being tested for cholesterol levels at age 20 and every five years thereafter. However, individuals with medical problems such as diabetes or with many heart attack risk factors may require more frequent testing. It is recommended that testing be discussed with a physician to determine an appropriate individual plan.

The good news about high cholesterol is that a healthy lifestyle can prevent high cholesterol from developing. An additional benefit of a healthy lifestyle is that it eliminates other risk factors for heart attack as well. Patients with high-risk cholesterol levels can usually reduce their cholesterol without medication.

Although some diseases increase cholesterol, the most dangerous cholesterol levels are the result of being overweight. The typical American diet contains more fat than the body can use, but there are ways to avoid excess fat. Some suggestions for a healthy diet include:

* Eat lean cuts of meat and remove visible fat.
* Avoid fried foods.
* Remove skin from chicken before cooking.

* Limit dairy products with high fat content, such as whole milk and sour cream. Skim milk and low fat cheeses are good alternatives.
* Eat more fiber. Three to five servings of vegetables and two to four servings of fruit each day will not only lower cholesterol but may also decrease the risk of certain cancers.

Exercise is another part of a low-cholesterol lifestyle. Regular exercise lowers cholesterol and promotes weight loss. It also reduces stress and lowers blood pressure. High blood pressure is an additional risk factor for heart attacks. Before beginning an exercise program, it's a good idea to discuss your plan with a physician.

Diet, weight reduction and exercise are not the only components of a low cholesterol lifestyle. Limiting alcohol use also helps. Men who consume more than two drinks of alcohol a day and women who drink more than one drink of alcohol a day are at increased risk of having elevated cholesterol.

Smoking also influences cholesterol levels. Smokers who want to quit should talk with their physician. Effective treatment is available.

High cholesterol is a killer, but the decision to live a healthy lifestyle can reduce the risk of a heart attack. See the dietician or wellness center personnel at your local medical facility for more information about cholesterol.

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Comments about and ideas for MEDNEWS are welcome. Story submissions are encouraged. Contact MEDNEWS editor, Earl Hicks, at email: mednews@us.med.navy.mil; Telephone 202/762-3223, (DSN) 762-3223, or fax 202/762-3224.

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